Medical Assistance Program Oversight Council November 8, 2013

Connecticut Department of Social Services

Making a Difference

Intensive Care Management Program

- CHNCT's Intensive Care Management program is URAC accredited in Case and Disease Management.
- URAC is a health care accreditation agency whose mission is to promote continuous improvement in the quality and efficiency of health care management through processes of accreditation, education, and measurement.
- Accreditation signifies the organization has undergone and passed a rigorous, independent, top-to-bottom review of every aspect of its operation, including the quality of care and level of service they provide. The reaccreditation process occurs every 3 years.
- The process by which accreditation is achieved involves a URAC review of the organization's program design, policies, and procedures followed by a 3 day, on-site survey. The on-site survey consists of a review of the organization wide practices and staff credentials, management and staff interviews, audits of Member case records, and program outcomes.

Intensive Care Management

Person-Centered Approach

DSS, State agencies, and CHNCT collaborated to define person-centeredness to serve as the framework for programs within Connecticut. Person-centeredness is defined as:

- providing the Member with needed information, education and support required to make fully informed decisions about his or her care options and, to actively participate in his or her self-care and care planning;

- supporting the Member, and any representative(s) whom he or she has chosen, in working together with his or her non-medical, medical and behavioral health providers and care manager(s) to obtain necessary supports and services; and

- reflecting care coordination under the direction of and in partnership with the Member and his/her representative(s); that is consistent with his or her personal preferences, choices and strengths; and that is implemented in the most integrated setting.

Intensive Care Management
Program Goals

Right Care ~ Right Time ~ Right Place

Intensive Care Management

Who are We?

- Multidisciplinary regional care teams are comprised of 131 staff:
  - Registered Nurse
  - Advanced Practice Registered Nurse (Family and Pediatric)
  - Social Worker
  - Human Services Specialist
  - Registered Dietician
  - Certified Diabetic Educator
  - Certified Child Birth Educator
  - Certified Wound Care Nurse
  - Care Coordinator
  - Pharmacist
  - Medical Director

- Specialized teams address the unique needs of members with:
  - Multiple unstable conditions
  - Medical with behavioral health needs
  - Chronic diseases such as:
    - Diabetes
    - Lung Disease
    - Asthma
    - Sickle Cell
    - Heart Failure
    - Hypertension
  - Maternity and newborn needs
  - Children and youth with special healthcare needs
  - Medical with unmet social needs

Intensive Care Management
How Do We Do It?

- Face to Face Outreach
  - Home, Shelter, Hospital (Inpatient, ED), Skilled Nursing Facilities, Provider Office, Community Settings
- Telephonic Support
- Assessment of members' needs
- Person centered care planning utilizing evidence based clinical guidelines
- Culturally and linguistically appropriate services taking into consideration the Member's beliefs and traditions for preferences such as diet and provider selection

Cultural Awareness

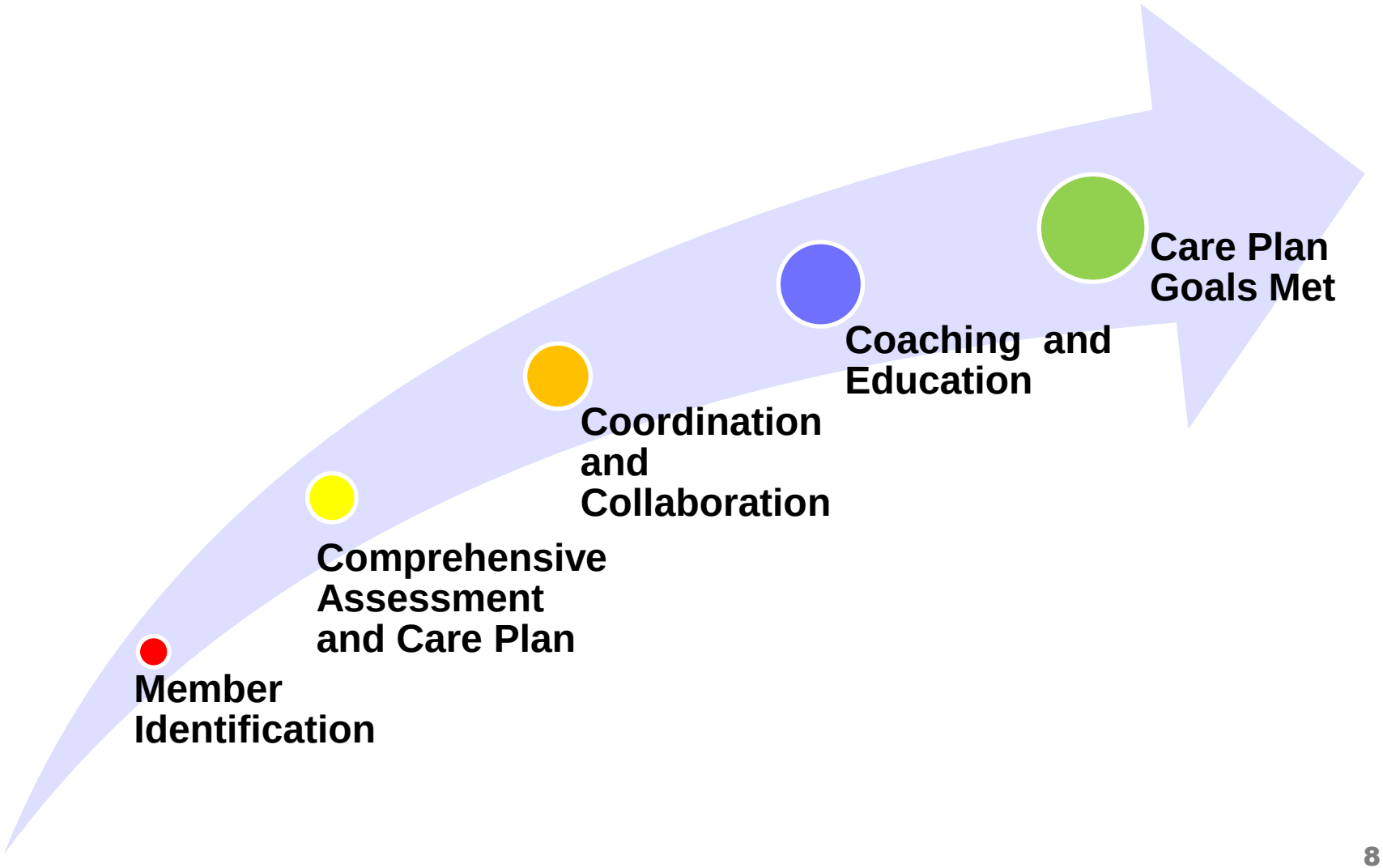
- Person-centered care means that a person's interests and concerns should be at the center of his or her own healthcare experience. ICM takes into consideration a member's cultural traditions, personal preferences and values. ICM utilizes *CultureVision*, a web-based learning guide developed by Cook Ross Inc., a nationally recognized consulting firm which provides diversity, inclusion, and cultural competency training to organizations across the U.S. and ten countries around the globe.

- This web-based tool is embedded in the assessment to aid the ICM Nurse in understanding the Member's culture related to:
  - How illness and health is viewed
  - Styles of language and communication (verbal and non-verbal)
  - How family structure and social relationships influence decisions
  - Views of self-care and disease prevention
  - Views of causes of illness and treatment
  - Food beliefs, diet customs and patterns
  - Attitudes and beliefs about mental health
  - Beliefs about labor, birth & after care

- In addition the ICM Nurse uses the language line to communicate with members in their preferred language both face to face and telephonically.

- Between January 1, 2013 and September 30, 2013, ICM utilized:
  - Language line 4,462 times for 36 different languages
  - *CultureVision* for 52 different cultures

Intensive Care Management Process



How does a Member get into ICM?

There is No Wrong Door

- **ASO CHNCT Staff (Utilization Management, Member Services, Appeals)**
- **Hospital Discharge Planning and ED Utilization**
- **Members/Caregivers**
- **Other ASOs**
- **Predictive Modeling and Data Analytics**
- **Providers**
- **State and Community Agencies**
- **Welcome Calls and Health Risk Screenings**

Comprehensive Assessment

The ICM Nurse, using a conversational approach and motivational interviewing techniques, engages the Member in order to perform a comprehensive assessment of the Member's needs, strengths, and barriers.

The assessment tool, used as a guide, is structured as two components: a core assessment, and condition-specific questions.

Core Assessment

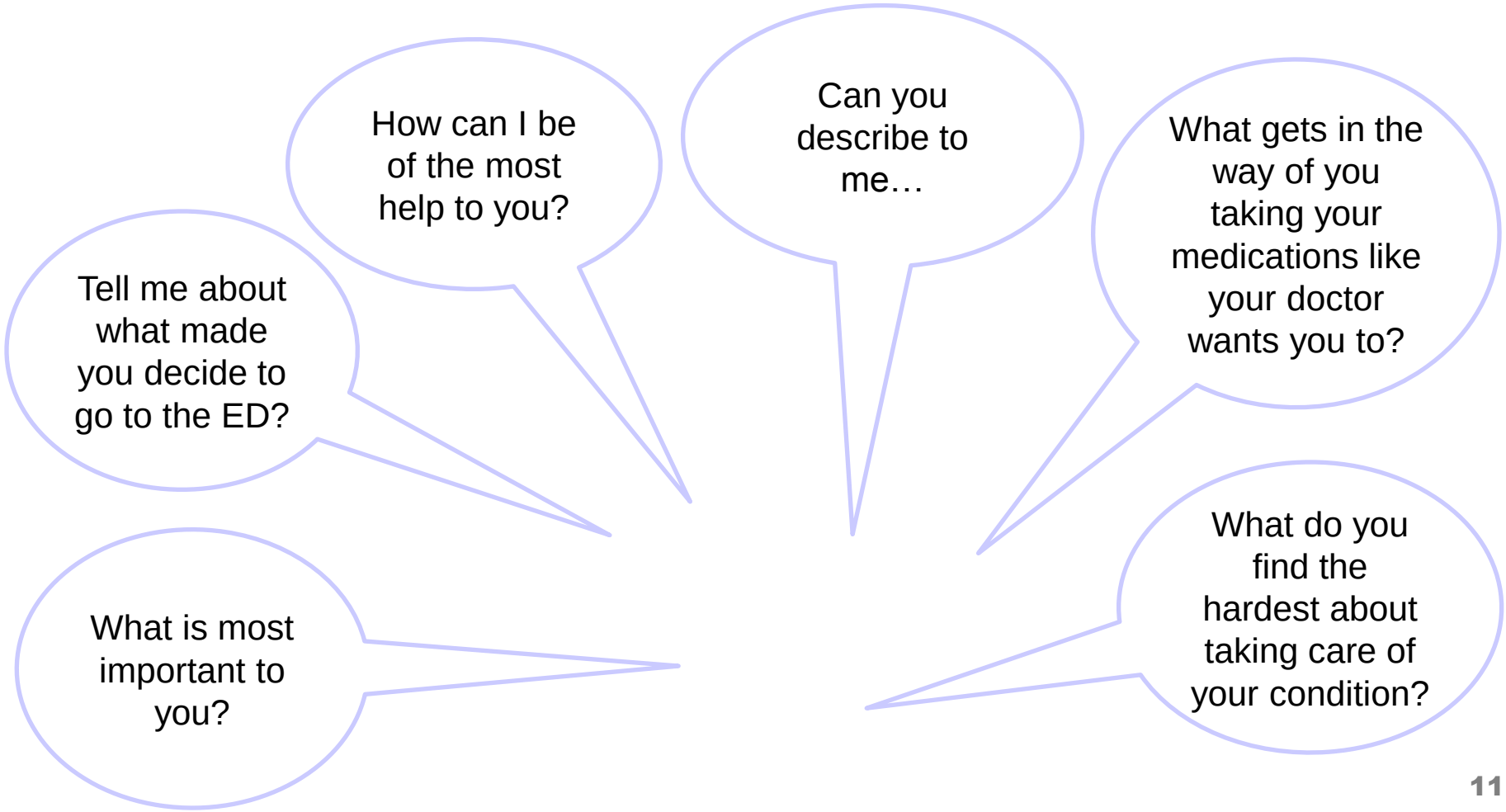
- ✓ Adequate food, safety and shelter
- ✓ Barriers to care
- ✓ Stress levels
- ✓ Self care abilities (functional)
- ✓ Medication understanding and safety
- ✓ Medical home engagement
- ✓ Depression screening
- ✓ Safety (past/present events)

Condition Specific

- ✓ Condition stability
- ✓ Health literacy
- ✓ Self care understanding
- ✓ Chronic disease coaching
- ✓ Motivational interviewing
- ✓ Member directed goal setting

Person-Centered Approach

Engaging and Assessing
"Let's talk about….."



Tools within the Assessment

Embedded throughout the assessment are supportive tools to assist with member engagement:

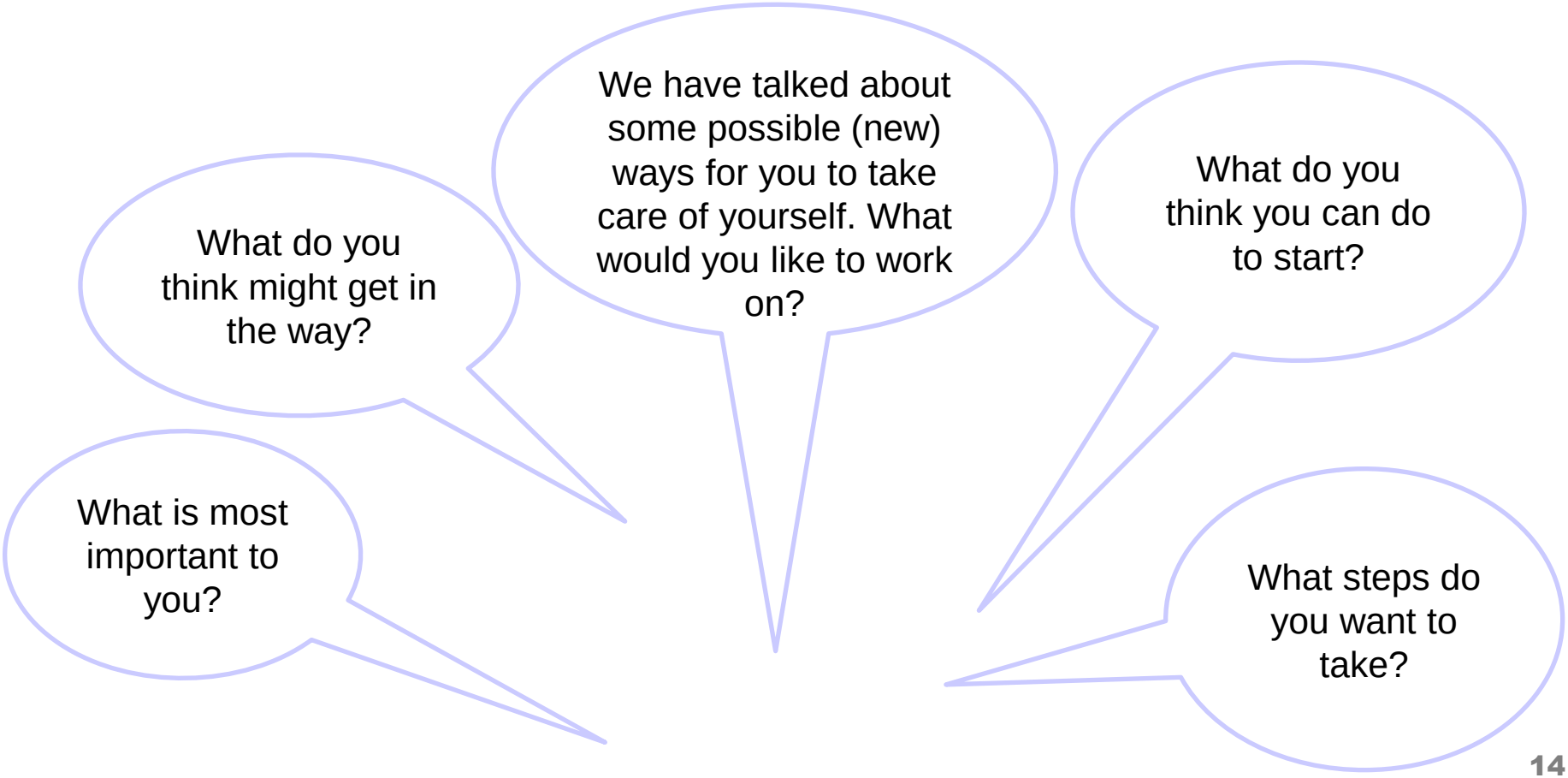
- Evidence based condition guidelines for member coaching
- Education coaching guides
- Age and gender appropriate preventive care guidelines
- Social and community resource information
  - Public assistance
  - Food and nutrition
  - Housing and shelter information

Tools within the Assessment (cont.)

- Cultural and health literacy resources
  - *CultureVision* web guide
  - Language line translation services
  - Ask Me 3™ (Good questions for your health)
  - Developmental milestones
  - Food guides
  - Medication schedules
  - When to call the doctor
  - Effects of caregiver stress
  - Stress and your health
  - Readiness to quit smoking tool
  - Women's health resources

Care Planning

As part of the assessment process, care planning begins with the member, provider, and whomever they wish to include. It promotes the member's choices and focuses on needed supports and services. In order to support goal setting, the conversation may include:



Immediate Needs Assessed

January 1, 2013 to September 30, 2013

Immediate Needs:

- 2,294 Members upon assessment had immediate needs related to:
  - Food
  - Housing
  - Safety
  - Pain

- Interventions include:
  - Collaboration with community support services
  - Coaching and education on community resources
  - Safety evaluations
  - Pain management assessments

Access to Providers Addressed:

- ICM facilitated provider connections for 4,111 members

Member Self-Direction in Setting Goals

ICM Nurse engaged with Ms. C who has diabetes and asthma and was a high user of both ED and inpatient services. Ms. C had medication adherence issues, did not understand her diet, and is a smoker.

With information, education, and support to make fully informed decisions about her care options Ms. C chose the following long-term goals:

- Maintaining a healthy diet
- Achieving a weight loss of 20 lbs
- Adhering to the MD prescribed asthma treatment plan
- Reducing use of ED and hospital admissions

In order to reach those long term goals, Ms. C chose to work on small action steps, or short term goals, that she wished to achieve by set time frames in order to:

- Learn how to plan a healthy menu
- Start walking 30 minutes per day, three times a week
- Reduce and eventually stop smoking
- Gain a better understanding of the use of asthma medications with exercise
- Recognize early symptoms and when to seek appropriate medical attention

ICM Coordination and Collaboration

Supporting the Member and any representative chosen in working together with his or her non-medical, medical, behavioral health providers and care managers to obtain necessary supports and services.

Coordinate and link members with providers to ensure consistent health care management:

- Primary care providers
- Specialists
- Behavioral health services
- Homecare
- Durable Medical Equipment
- Therapies (OT/PT/Speech)
- Rehabilitation services
- Dental
- Transportation
- Supportive housing

Collaborate with Members:

- Family/Designated caregivers
- Healthcare providers - physical and behavioral health
- Other State Agencies
  - DCF, DDS, DPH, SBHCs, DMHAS, DSS, CTBHP, CTDHP, HUSKY Plus, WIC, Healthy Start
- Waiver program administrators
- Community supports
  - Community action agencies
  - 2-1-1 Infoline/Child development infoline
  - Advocacy and charitable agencies
  - Aging and disability resource centers

Human Services Specialists
An Extension of ICM
January 1, 2013 to September 30, 2013

- Provide face to face visits to address social determinants of health by:
  - Coordinating with PCP and ICM when non-medical issues are identified
  - Connecting Members to community based resources and agencies
  - Building on Members natural support systems
  - Encouraging self-advocacy in accessing community resources
- Assist in identifying children for early intervention services by:
  - Completing Ages and Stages Questionnaires for children under 5 ½ years of age who are not already engaged in early intervention programs. Results are provided to ICM and PCP

Type of Resource Assistance Needed	Number of Referrals Coordinated
Housing information	929
DSS benefit information	766
Utility assistance	699
Food pantries	696
Clothing donations	627
Household goods	552
Legal services	521
Behavioral health	504
Employment	460
Dental	449

ICM Coordination for Members with Complex Medical and Behavioral Health Conditions

To avoid duplication of services and improve coordination of care, Members with medical and behavioral health needs are assigned to the following teams:

- ICM Complex Medical with Behavioral Health (non-SPMI)
  - Co-managed with the CT Behavioral Health Partnership
- ICM Complex Medical with SPMI
  - Co-located Specialized Team of ICM Behavioral Health RNs at CHNCT
- Behavioral Health without Complex Medical
  - Referred to CT Behavioral Health Partnership

*SPMI-Serious and Persistent Mental Illness

Coordination for Behavioral Health Needs at Any Level of Member Engagement

- Inpatient Level
  - Multidisciplinary twice weekly hospital case rounds that include CTBHP staff to:
    - Coordinate hospital discharge planning needs
    - Create strategies for member engagement
    - Discuss medication adherence and nutritional consultation needs
    - Establish appropriate ICM team assignment and determine the need for member contact while inpatient

Coordination for Behavioral Health Needs at Any Level of Member Engagement

- Community Level
  - Regional ICM case rounds held monthly
  - Focused case rounds of high ED users and members with pain management issues held twice monthly
  - Meeting with CTBHP, held monthly, for members receiving home care services providing an opportunity to identify members with ICM needs
  - ICM Case rounds with CTBHP to discuss actively co-managed members held monthly
  - Crisis interventions with CTBHP for members identified with a behavioral health issue
  - Coordination between ICM, CTBHP, and DMHAS (Advanced Behavioral Health) for members with substance abuse treatment

ICM Coordination of Services for Children and Youth With Special Healthcare Needs

- Coordination of Services are Co-Managed with:
  - Connecticut Medical Home Initiative for Children and Youth with Special Healthcare Needs
  - Connecticut Birth to Three Systems for Intensive Therapies
  - HUSKY Plus
    - The program for children up to age 19, which provides supplemental coverage of goods and services for HUSKY B children with intensive physical health needs
- Intensive Care Managers also provide information on:
  - Local and national organizations based on the child's medical condition(s)
  - Parent supports and networks such as:
    - PATH (People Acting to Help)
    - CT Family Support Network
    - CT Parent Advocacy Center

Collaboration for a Child with Special Healthcare Needs

D.N. is a young boy with Down's syndrome, has multiple congenital conditions, and asthma. He lives with his mother, who has health, financial issues, and a limited understanding of her son's medical conditions. Due to young D.N.'s intense reaction to environmental stimuli, assistance was required in coordination of specialty care.

In working together with the member, parent, provider, and HUSKY Plus, necessary supports and services were coordinated for:

- The Child:
  - Specialty Vision Services to secure eyeglasses
  - Outpatient Speech Therapy to increase member's ability to communicate
  - Specialists to treat congenital condition
  - Dentist specializing in children and youth with special healthcare needs
  - HUSKY Plus for continuation of long-term speech therapy needs
- The Mother
  - Teaching to support Member's specialized healthcare needs
  - PCP identified for parent to address unmet healthcare needs
  - Community resources provided to address parent's need for food, household items, and employment

ICM Coaching and Education

Reflecting care coordination under the direction of and in partnership with the Member and his/her representative(s); that is consistent with his or her personal preferences, choices and strengths; and that is implemented in the most integrated setting

- Chronic Condition Coaching:
  - Knowing their numbers (Blood pressure, Blood Glucose, Cholesterol, Weight, Peak Flows, etc.)
  - Knowing their targets
  - Knowing their triggers
  - Knowing the steps to take
  - Action Planning
    - *What would you do if…?*
  - Knowing who to call and when
- Preventive Care Coaching
  - Know When
  - Know Why
  - Know Where
    - Well Care Visits
    - Screenings
    - Immunizations/Flu Shots
    - Dental and Vision

Tools for Member Self-Empowerment

- HUSKY Health Website which directs member's to:
  - Krames Disease Education (4,500 health related topics)
  - Providers
- 24/7 Nurse Advice Line
- CHOICES (Nutrition Education Workshops)
- Connection to associations such as:
  - American Diabetes Association
  - American Cancer Society
  - American Heart and Lung Association
  - March of Dimes
  - Sickle Cell Association
  - National Heart, Lung, and Blood Institute
  - American College of Obstetrics and Gynecology
  - American Academy of Pediatrics/Bright Futures
  - Centers for Disease Control

Tools for Member Self-Empowerment (cont.)

- Health reminders are provided to Members in a variety of ways (phone, mail, text message). Reminders focus on:
  - Child and adult well care
  - Preventive screenings
  - Linkage to primary care

- Health coaching via scheduled text messaging:
  - Text 4 Baby (Prenatal/Postpartum/Child to age 1)
  - Text 4 Kids (Children and Adolescents, implement 1Q2014)
  - Text 4 Life (Adults, implement 1Q2014)
  - Care 4 Life (Diabetes, implement 12/13)

Member Education and Coaching

ICM engaged with Mr. R, a 59 year old Spanish speaking male, recently discharged from the hospital after experiencing a heart attack. Mr. R was overweight and had a limited understanding of his prescribed diet and medications.

To support the physician prescribed treatment plan, the Spanish speaking ICM nurse met with the Mr. R and his wife face to face and had phone follow-ups. These are the areas that Mr. R and his wife chose to learn more about:

- Early warning signs and symptoms of heart attacks and high blood pressure along with Spanish language mailing to support teaching
- Importance of taking all medications as prescribed
- Healthy food preparation and choices that are within his cultural preferences
- Maintaining all follow up appointments

Care Plan Goals Met

A member will graduate from ICM when:

- Member, Caregiver, Provider agrees the Member's healthcare goals have been met
- Member/Caregiver:
  - Demonstrates self-advocacy
  - Expresses understanding of appropriate care and resources
  - Successfully manages their condition(s)

Upon Graduation from ICM, Members are informed that:

- They can seek ICM services for changes in their health status or condition(s)
- They have continued access to other services including:
  - 24/7 Nurse Advice Line
  - Health reminders
  - Appointment scheduling assistance (Medical, Dental, Transportation)
  - Community Support Services

Care Plan Goals for a High-Risk Pregnant Member

Ms. H is a 26 year old with a high-risk pregnancy related to her past substance abuse issues, hypertension, asthma, and homelessness.

ICM collaborated with the member and provider to identify the steps that would lead her to delivery of a healthy newborn. The member's goals included:

- Understanding the importance of keeping all routine prenatal appointments
- Learning the signs and symptoms of high blood pressure such as headache, blurred vision, and severe heartburn to report to her OB/GYN
- Establishing an asthma action plan with her provider
- Missing no counseling sessions of her drug rehab program
- Continuing to attend the drug abuse rehab program by staying at the residential center throughout her pregnancy
- Delivery of well baby within1-2 weeks of her estimated due date without complications

Care Plan Goals Met for a High-Risk Pregnant Member

- Successful Member Outcomes:
  - Achieved normal vaginal delivery of full term newborn
  - Maintained a drug free pregnancy
  - Scored negatively for postpartum depression
  - Understands importance of post-partum care and maintaining follow up appointments
  - Adherence to physician prescribed asthma action plan
  - Secured behavioral and community supports
  - Successful self advocacy in accessing stable housing and community resources
  - Knowledgeable regarding how to access ICM, Nurse Advice Line, Logisticare, CTBHP, and CTDHP for future needs after graduation

Member Engagement

January 1, 2013 to September 30, 2013

Total Outreached: 46,733	• Members identified and outreached for ICM enrollment
Enrolled Only: 3,500	• Members who received short-term care management but did not agree to long-term ICM
Engaged: 8,636	• Members who have completed an assessment and have established a person-centered Care Plan
Total Enrolled and Engaged: 12,136	• Members who have had an active case in ICM

ICM Member Population

January 1, 2013 to September 30, 2013

Eligibility Group	Total Enrolled ICM Members	12,136	
HUSKY A	3,968	0-20 Years Old	1,691
		21 and Older	2,277
HUSKY B	100	0-19 Years Old	100
HUSKY C	4,560	0-20 Years Old	37
		21 and Older	4,523
HUSKY D	3,387	19-20 Years Old	44
		21 and Older	3,343
Limited Benefit	3	0-20 Years Old	1
		21 and Older	2
Charter Oak	118	21 and Older	118

ICM Referral Sources

January 1, 2013 to September 30, 2013

Referral Source	Number of Referrals	Percentage of Total Enrolled
ASO CHNCT Staff (Utilization Management, Member Services, Appeals)	446	4%
Hospital Discharge Planning and ED Utilization	3,331	27%
Members/Caregivers	600	5%
Predictive Modeling and Data Analytics	7,044	58%
Providers	340	3%
State and Community Agencies	129	1%
Welcome Calls and Health Risk Screenings	221	2%
Other	25	<1%
Total	**12,136**	**100%**

Short-Term Care Management for Enrolled Members

- Members who enroll in ICM who have a short term presenting need, but do not agree to engage in long-term care management are provided care coordination such as:
  - Facilitating coordination of pharmacy needs (e.g. needing a new prescription or renewal)
  - Referral to Medication Therapy Management (MTM pharmacy care management program)
  - Providing resources to members who are spending down to income eligibility
  - Coordinating services when current providers are unable to meet service needs (e.g. homecare, equipment, outpatient services)
  - Assistance in locating new primary care provider or specialist due to multiple medical needs

Member Identification: Predictive Modeling
What is it?

- The CHNCT Predictive Modeling and analytics tool which combines elements of patient risk, care opportunities, and provider performance to identify members requiring care management services.
- The tool uses the Johns Hopkins ACG® (Adjusted Clinical Group) logic to identify members' current and predicted risk and severity. Grouped as high, moderate, or low risk.
- Reports are available at both a summary and detail level for members, overall population, and providers/groups.
- In addition to the reports to identify members, the tool also provides:
  - Member risk
  - Provider performance
  - Quality (HEDIS®) Health Measures
  - Financial/Utilization

Predictive Modeling
How is a Risk Score Generated?

- Data Sources**:** Medical and Pharmacy Claims, Member/Provider Records, Lab Data

- Factors Used to Determine Risk:
  - Overall Disease Burden (ACGs)
  - Disease Markers (EDCs)
  - Special Markers (Hospital Dominant Conditions and Frailty)
  - Medication Patterns
  - Utilization Patterns
  - Age and Gender

- Results: Current and Predicted Risk Score

Predictive Modeling
How does ICM use it?

- ICM uses reports produced by predictive modeling to identify high-risk members who may benefit from care management
- Predictive Modeling reports can be filtered to prioritize ICM outreach efforts based on:
  - Current or potential health risks
  - High utilization of the Emergency Department
  - Frequency of inpatient admissions and 30 day readmissions
  - Number and type of chronic conditions
  - Gaps in care
  - Number and type of physicians utilized
  - Number of medications
  - Member demographics
  - Current and predicted risk score

Medical Risk Levels of Enrolled and Engaged Members

January 1 2013 to September 30, 2013

Risk Level	Engaged	Enrolled Only	Total
High	7,347	2,118	9,465
Moderate	1,278	1,336	2,614
Low	10	36	46
Pending Assessment	1	10	11
Total	**8,636**	**3,500**	**12,136**

Member Identification: Other Data Analytics

In addition to predictive modeling, ICM utilizes other data sources to identify the following categories of members with potential care opportunities:

- Pregnant Members:
  - OB P4P Prenatal Notification Forms, Prenatal Vitamin report, Daily DSS Eligibility files
- Members outside the range of normal Clinical Values:
  - Pharmacy Adherence report, Lab data reports
- New Members:
  - Health Risk Screening
- Early identification of Members in need of follow up:
  - Hospital readmission report, ED notifications when provided real time by the hospital (currently receiving from 2 hospitals), Easy Breathing (Asthma Program) report

Conditions of Members Enrolled in ICM

As of September 30, 2013

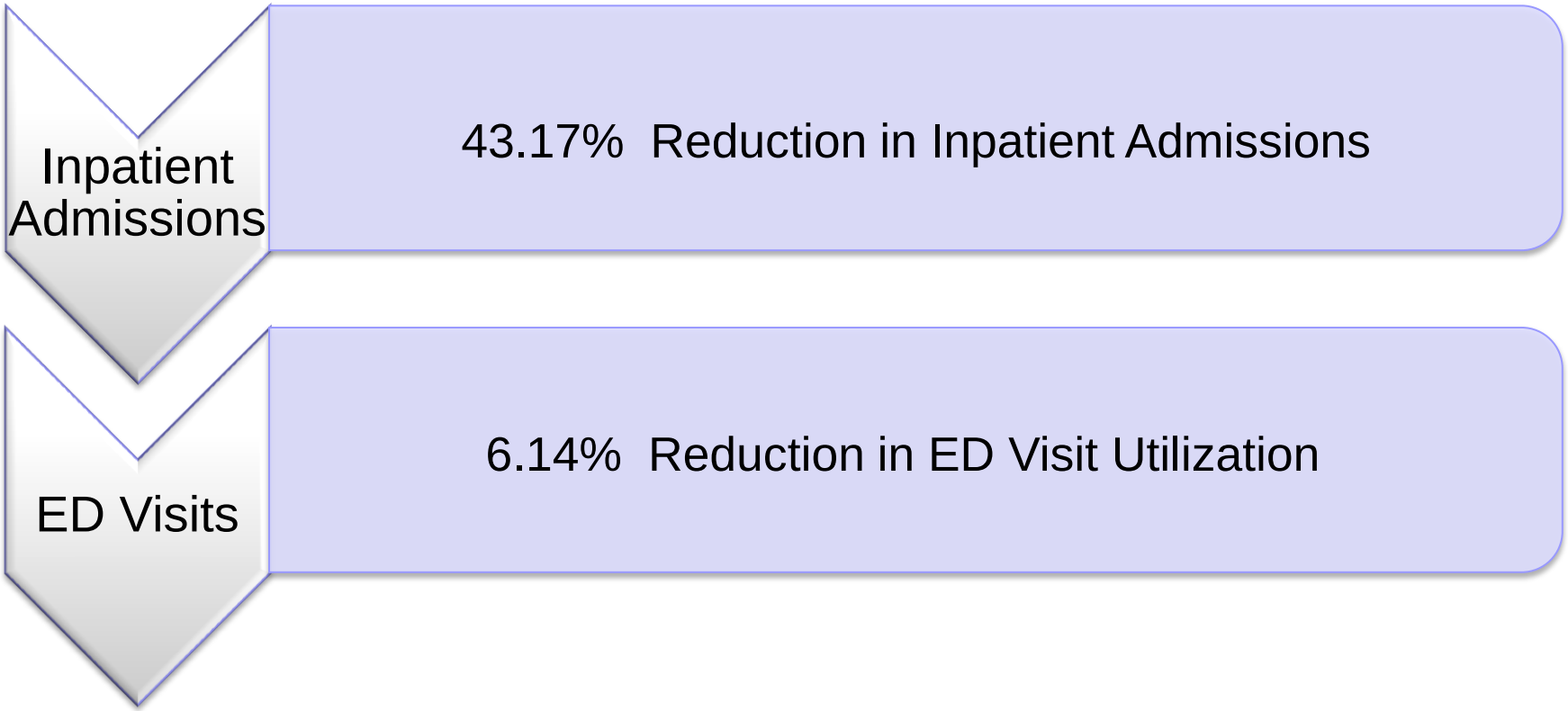
- ICM Members often have multiple chronic conditions;
  - Percent of enrolled ICM Members with 1-4 Chronic Conditions: 57%
  - Percent of enrolled ICM Members with 5 or more Chronic Conditions: 43%

Top Medical Condition Categories
Cardiac Conditions (including Hypertension)
Gastrointestinal
Behavioral Health
Neuromuscular and Degenerative
Diabetes
Asthma
Injuries
Respiratory
Renal
Congenital, Developmental
Cancers, Auto-Immune, Sickle Cell

Intensive Care Management

Program Outcomes for Members Engaged in ICM

between January 1, 2012 and October 31, 2012*



* Claim data comparison 6 months pre and 6 months post ICM engagement

ICM Member Satisfaction

A vendor is contracted to complete a satisfaction survey with members enrolled for 6 months to solicit program feedback for continuous quality improvement. Results from first half 2013 indicate:

- 95% would likely recommend the care management program to a friend or family member.
- 94% reported at least some improvement in their health and ability to take care of themselves.
- 92% indicated that the care management program encouraged or helped them maintain getting a yearly check-up.
- 90% indicated that the care management program encouraged or helped them take their medications as prescribed by the doctor.
- 91% indicated that the care management program encouraged or helped them maintain getting annual follow-ups like an eye exam or flu shot.

Questions?